



West Virginia

# EPI-LOG

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## Vaccines For Children program aims to improve child immunization

The Vaccines for Children (VFC) program is a federally funded program that provides free vaccines to eligible children at more than 400 provider sites in West Virginia. The program was established by the Centers for Disease Control and Prevention (CDC) following a measles epidemic that occurred from 1989 to 1991. More than 55,000 cases were confirmed, and 130 deaths were attributed to measles during that outbreak. Through intense investigation of this epidemic, CDC discovered that more than half of the children who had measles had not been vaccinated, despite having a health care provider.

Congress, partly in response to this outbreak, passed the Omnibus Budget Reconciliation Act (OBRA) on August 10, 1993, creating the VFC program. On October



1, 1994, the VFC program became operational. Vaccines available through this program are those recommended by the Advisory Committee on Immunization Practices (ACIP). These vaccines protect babies, young children and adolescents from 16 diseases; the VFC program helps ensure all children have a better chance of getting their recommended vaccinations on schedule.

The VFC program, known as section 1928 of the Social Security Act, is an entitlement program for eligible children age 18 and younger. Along with age, additional eligibility criteria must be met for a child to receive vaccines

(See **VFC**, page 2)

## Statewide Disease Facts & Comparisons

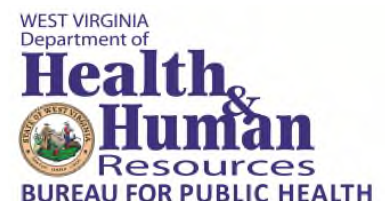
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& Prevention Services

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Earl Ray Tomblin, Governor  
Karen L. Bowling, Cabinet Secretary  
Dr. Rahul Gupta, Commissioner and  
State Health Officer

*(VFC, continued from page 1)*

through the VFC program. In order to determine eligibility, all participating providers must ensure the child is less than 19 years of age and is one of the following: Medicaid-eligible, uninsured, underinsured, or American Indian or Alaska Native. Once eligibility is determined, the VFC provider gives the vaccines to the child at no cost. The VFC program prohibits charging for any vaccines administered through its program. This does not apply to additional charges incurred by the provider, such as office visit, lab or exam fees, or a vaccine administration fee. A vaccine administration fee can be charged for each vaccine administered, however, it cannot exceed the state fee cap, which is \$19.85 for any child who is uninsured or whose insurance does not cover vaccine administration. Therefore, this fee cap does not apply to children with Medicaid coverage or whose insurance covers the vaccines administered.

However, it is important to note that as part of the VFC enrollment process, providers must agree to not refuse any vaccination to a child due to the parent or guardian's inability to pay the vaccine administration fee.

Nationwide, more than 44,000 doctors are enrolled in the VFC program. These providers represent public health clinics, private physician offices, as well as Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC). Providers who wish to participate in the program complete an enrollment packet, which consists of a Provider Agreement that covers the program's requirements; a Provider Profile, which determines the number of children served by the provider; a Provider Address Form for vaccine shipments; and a VFC Storage Agreement. Continuation in the program requires annual reenrollment with the above documents.

To ensure compliance with the program's guidelines, the VFC program requires site visits be conducted on a bi-annual basis to all enrolled providers. The West Virginia Division of Immunization Services (WVDIS) oversees this program and has a team of five dedicated individuals who visit each provider on an annual basis. The VFC program consists of various types of visits covering new enrollment, education, compliance, and unannounced monitoring of storage and handling. While all parts of the program and visit are essential, three of the most

important aspects of a visit include ensuring a provider is screening for and documenting VFC eligibility correctly, that vaccine documentation is correct and includes all federal requirements, and that vaccines are being stored under proper storage and handling guidelines. Lack of adherence to any program requirement could result in a misuse of federally funded vaccines or administration of a compromised vaccine. Misuse of the vaccine could constitute fraud or abuse, in which case a provider may be required to reimburse the program for the cost of the misused vaccine. Administration of a compromised vaccine could result in a child being unprotected from a



potentially fatal vaccine-preventable disease, a provider needing to re-vaccinate children who received the compromised vaccine, as well as possible loss of trust for the provider with their parents and the community.

The CDC requirement for site visits is to conduct 50% compliance and 5% unannounced storage and handling annually. The WVDIS field staff completed a total of 228 (57%) compliance and 28 (7%) unannounced storage and handling visits in 2015. In addition to compliance and unannounced storage and handling, the staff has completed 15 new enrollment and eight educational visits this year.

The majority of the problems found during the visits conducted in 2015 included failure to document all federally required information on the immunization record, clinics/practices that did not have the most up-to-date Vaccine Information Statement (VIS) to provide to the patient, expired vaccines, and no water bottles or ice packs in the storage unit. The DIS field staff strives to correct such issues discovered during site visits and to educate providers on all CDC requirements and recommendations.

Looking forward to visits conducted in 2016, the WVDIS plans to replace the certified/calibrated thermometers with digital data loggers (continuous monitoring systems) as part of CDC recommendations. DIS field staff will begin conducting adolescent assessments along with the childhood assessments to obtain coverage rates for West Virginia's adolescent population. Another important goal for 2016 is to improve VFC compliance for all VFC providers by providing education and training and updating providers on any changes in CDC requirements and recommendations. ❖

**West Virginia AIDS and HIV Infection Cases Diagnosed by  
Age Group, Gender, Race and Exposure Category  
Cumulative through December 31, 2015**

Characteristic	HIV/AIDS ‡		HIV-NA ‡		AIDS ‡	
	No.	%	No.	%	No.	%
<b>Age at Diagnosis §</b>						
< 13 years	23	1	12	1	11	1
13 - 24 years	338	12	212	24	126	7
25 - 44 years	1,789	64	530	60	1,259	66
45 - 64 years	593	21	124	14	469	25
65 + years	43	2	7	1	36	2
<b>Gender</b>						
Males	2,250	81	661	75	1,589	84
Females	537	19	224	25	313	16
<b>Race/Ethnicity</b>						
White	2,076	74	612	69	1,464	77
Black	585	21	223	25	362	19
Other*	126	5	50	6	76	4
<b>Exposure Category</b>						
Male-to-male sex (MSM)	1,483	53	444	50	1,039	55
Injection drug use (IDU)	393	14	118	13	275	14
MSM/IDU	127	5	28	3	99	5
Heterosexual contact	397	14	146	16	251	13
Perinatal	24	1	12	1	12	1
Other/Unknown†	363	13	137	15	226	12
<b>Total</b>	<b>2,787</b>	<b>100</b>	<b>885</b>	<b>100</b>	<b>1,902</b>	<b>100</b>

Notes: These are HIV/AIDS case numbers reported to the West Virginia Department of Health and Human Resources as of December 31, 2015. No adjustments were made for reporting delays. AIDS data includes reports from April 1984 through December 31, 2015; HIV data includes reports from January 1989 through December 31, 2015. Federal prisoners have been excluded. Percentages may not add to 100% due to rounding.

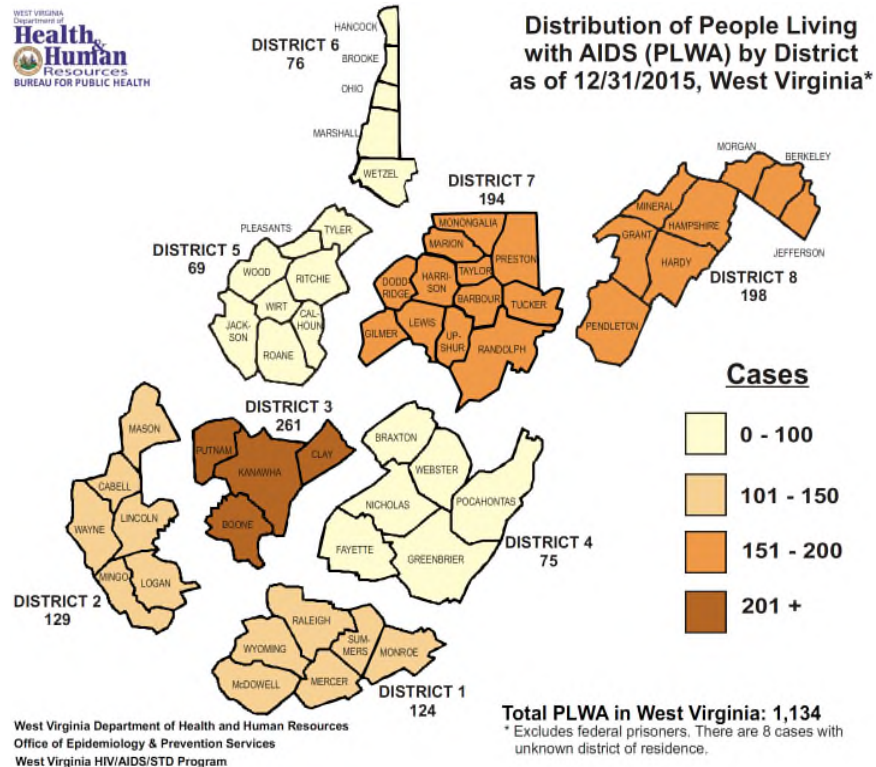
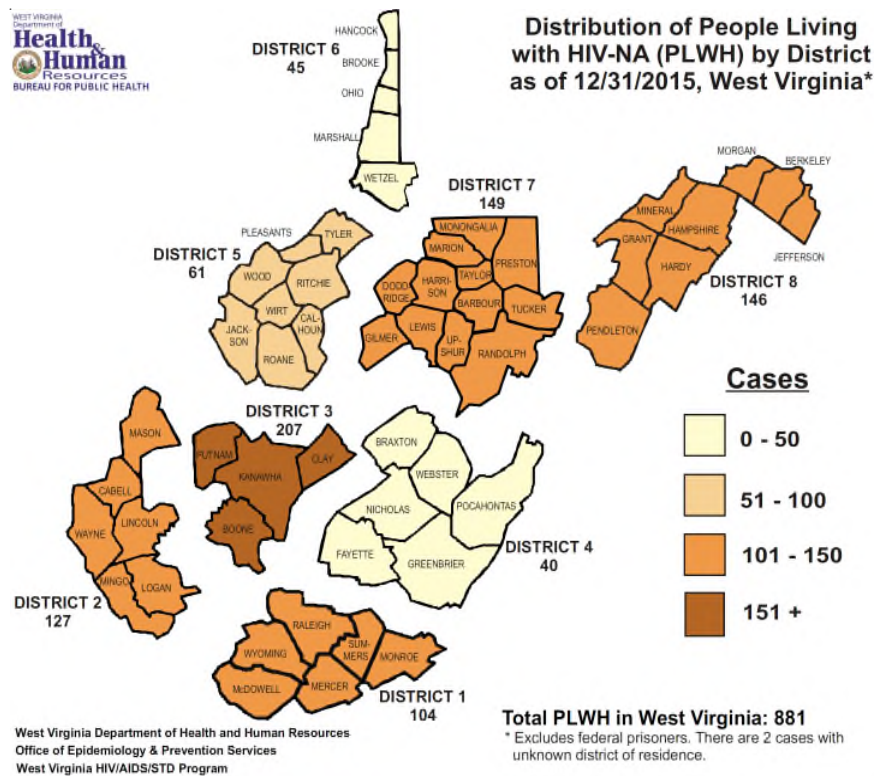
‡ HIV/AIDS provides information on the person's earliest diagnosis of HIV or AIDS in West Virginia. HIV-NA provides information on individuals diagnosed with HIV but not AIDS in West Virginia. These individuals may have been diagnosed with AIDS in another state. Individuals with AIDS may or may not have been diagnosed with HIV in West Virginia.

\*Other race categories include Hispanic, Asian, Native Hawaiian, Pacific Islander, American Indian, Alaskan Native, Multiple Races, and Unknown race.

†Other/Unknown risk categories include hemophilia, blood transfusion, and risk not reported or identified.

§Total includes one person with unknown age at diagnosis.





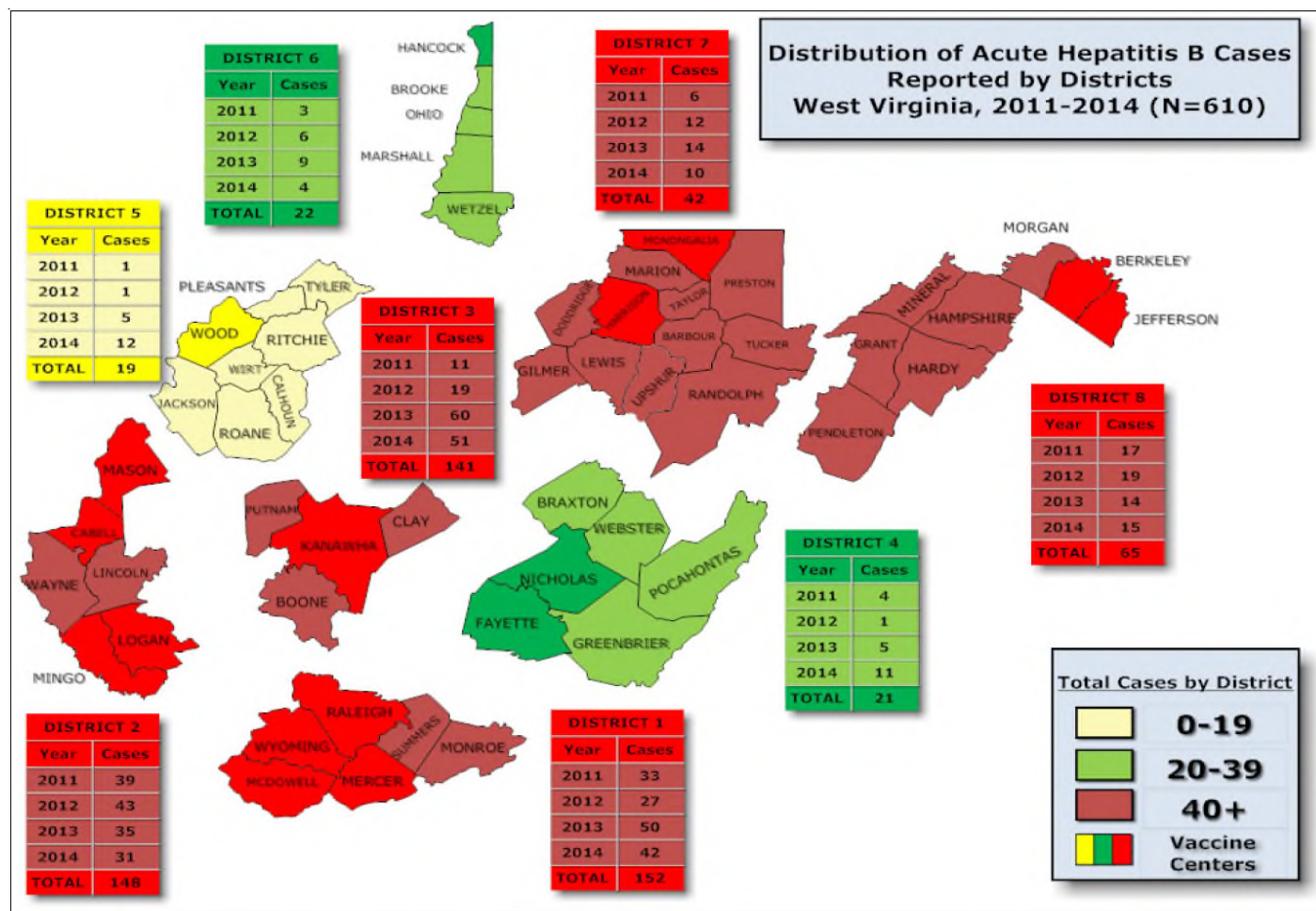
# Vaccination program aims to loosen the grip of hepatitis B on West Virginia

The West Virginia Department of Health and Human Resources, Bureau for Public Health, Office of Epidemiology and Prevention Services (OEPS) implemented the West Virginia Hepatitis B Vaccination Pilot Program (WVHBVPP) in January 2013. West Virginia's goal was to decrease the incidence of new infections of hepatitis B virus (HBV) by targeted outreach efforts to vaccinate high-risk populations with HBV in substance abuse centers, correctional facilities and HIV treatment providers.

As of 2013, West Virginia had the highest rate of acute HBV in the United States, with 10.6 cases for every 100,000 residents, compared to 0.9 per 100,000 nationwide. In 2014, West Virginia reported a slight decrease in the HBV rate with 10.0 per 100,000 residents. OEPS ordered a total of 11,484 doses of HBV vaccines for the WVHBVPP. More than 10,000 doses of vaccine have been administered to high-risk populations.

Strategies were incorporated to reach adults at high risk for HBV infection in settings serving high-risk populations, such as STD clinics, HIV care facilities, correctional facilities, and substance abuse treatment/injecting drug use (IDU) facilities. All participating local health departments (LHDs) were required to implement standing orders, provide education, vaccinate all adults requesting protection from HBV infection without acknowledging a specific risk factor, and vaccinating all adults who report risks for HBV infection.

(See *Hepatitis*, page 6)



*(Hepatitis, continued from page 5)*

STD clinics conducted outreach at identified substance abuse locations within their counties. Client reminder recalls were utilized, and reminder notices were given to patients for follow-up appointments. OEPS conducted site visits at all participating sites, providing HBV vaccination educational materials, consultation, guidance and feedback. Contract agreements were created with HIV care providers. HIV care facilities provided the HBV vaccine to HIV patients during their routine care. Since they already provided hepatitis vaccinations to patients, they had the capacity to participate in the WVHBVPP.

The WVHBVPP implemented strategies based on state epidemiological data of acute HBV infection rates and risk factors. OEPS targeted adults in settings serving high-risk populations. All sites had the capacity to properly store, handle and administer HBV vaccine and meet the expectations of the program.

The Adult Hepatitis B Coordinator (AHBC) gave guidance to all participating sites to provide HBV vaccination protocol, conduct site visits, and provide technical assistance as needed by phone or email.

Most of the participating sites provided outreach to substance abuse programs in their counties, focusing on patients enrolled for at least 30 to 45 days. This strategy allowed the best scenario for administering two doses in the series while the patient was still in care.

At the end of the funding period, 89% of the patients eligible for HBV vaccination accepted the first dose. 59% percent of first-dose recipients accepted the second dose, and 32% accepted the third dose. Documentation was collected on a monthly basis from all participating sites by the use of the West Virginia Hepatitis B Vaccination Collection Screening tool. On these screening forms, the participating sites reported the setting, age, race/ethnicity, sex, and risk factor for HBV infection.

One of the major challenges for all participating sites was getting patients to return to the LHD/STD clinic for the second and third doses of the HBV vaccine. Another challenge was finding the time and staff to conduct outreach

Setting	Number of Sites
HIV Care Facilities	3
LHDs/STD Clinics	17
Correctional Facilities	5
Substance Abuse Treatment/IDU Facilities	5

Risk Factors	Frequency	Percent
Do not want to answer, but would like Hepatitis B vaccine	377	7.82%
Persons seeking evaluation or treatment for STD	159	3.30%
Sexually active persons who are not in long-term monogamous relationship	108	2.24%
Current or recent injection drug user	61	1.27%
Household contact of a person with Hepatitis B infection	51	1.06%
Diabetes	44	0.91%
Sexual partner of a person with Hepatitis B infection	36	0.75%
Chronic liver disease	34	0.71%
Other risk factor/s	31	0.64%
Men who have sex with men (MSM)	26	0.54%

in more locations, to consistently give vaccines to high-risk populations. It should be noted that completing the vaccination series on the transient population was difficult.

Some of the lessons learned over the past three years included LHDs gaining an understanding of the need to provide hepatitis B vaccinations to high-risk populations and the importance of utilizing participating vaccination sites with a strong commitment to the program.

Vaccination completion rates can be improved by encouraging the participating sites to use a variety of simple measures, such as follow-up appointments before the patient leaves and reminder recall notifications. In addition, patients must be provided education on the importance of completing the HBV three-dose series. Some STD clinics were more successful in outreach efforts to correctional facilities, day report centers, and drug treatment centers, but all participating sites were successful in their efforts to vaccinate high-risk populations in these particular settings. One of the main successes of the program was getting more high-risk individuals vaccinated who would otherwise not get vaccinated due to cost.

*(See Hepatitis, page 11)*



# West Virginia Infectious Disease Outbreak Report

## October - December 2015

### Introduction

In West Virginia, outbreaks are immediately reportable to the local health departments (LHDs), regardless of setting, as per Reportable Disease Rule 64CSR7. LHDs, in collaboration with the West Virginia Bureau for Public Health, Division of Infectious Disease Epidemiology (DIDE), investigate all reported outbreaks. DIDE provides outbreak surveillance reports on a monthly and annual basis, and upon request. This report provides a brief description of confirmed outbreaks during the fourth quarter of 2015. All data provided are provisional.

### Methods

Data on outbreaks are routinely compiled in Microsoft Excel 2010. Data analyzed for the purpose of this report include information on outbreak type and setting, reporting region, time of reporting to LHDs and DIDE by region, clinical diagnosis, and laboratory information.

### Results

During the months of October, November, and December 2015, there were 42 outbreaks reported in West Virginia. Of the 42 reported outbreaks, 39 (93%) were confirmed as outbreaks or clusters of disease. Three were investigated and determined not to be outbreaks. Twenty-one were reported from healthcare facilities, 6 from schools, 4 from communities, 3 from daycare facilities, 2 from correctional facilities, 1 from a group home, and 2 were part of multi-state investigations.

Among the 21 healthcare-associated outbreaks reported, 20 (95%) were reported from long-term care facilities (LTCFs) and 1 from a hospital.

The following tables summarize the confirmed outbreaks:

### Rash Outbreaks from October-December 2015 (n=10)

Type of Outbreak or Cluster	Number of Outbreaks	Outbreak Setting	Laboratory Testing
Scabies	6	3 LTCFs	2 Not Done 1 Lab Confirmed
		1 Correctional Facility	Not Done
		1 School	Not Done
		1 Hospital	Not Done
Hand, Foot, and Mouth Disease	3	2 Daycare Facilities	Not Done
		1 School	Not Done
Undifferentiated Skin Rash	1	1 Daycare Facility	Not Done

(See **Outbreaks**, page 8)

(Outbreaks, continued from page 7)

**Respiratory Illness Outbreaks from October-December 2015 (n=10)**

Type of Outbreak or Cluster	Number of Outbreaks	Outbreak Setting	Laboratory Testing
Rhinovirus Respiratory Illness	3	2 LTCFs	PCR* Confirmed
		1 Community	PCR* Confirmed
Pertussis	2	1 Community	PCR* Confirmed
		1 School	PCR* Confirmed
Influenza	1	1 LTCF	Rapid Test
Acute Respiratory Illness	4	4 LTCFs	2 Negative 2 Not Done

\* PCR: Polymerase Chain Reaction

**Enteric Disease Outbreaks from October-December 2015 (n=19)**

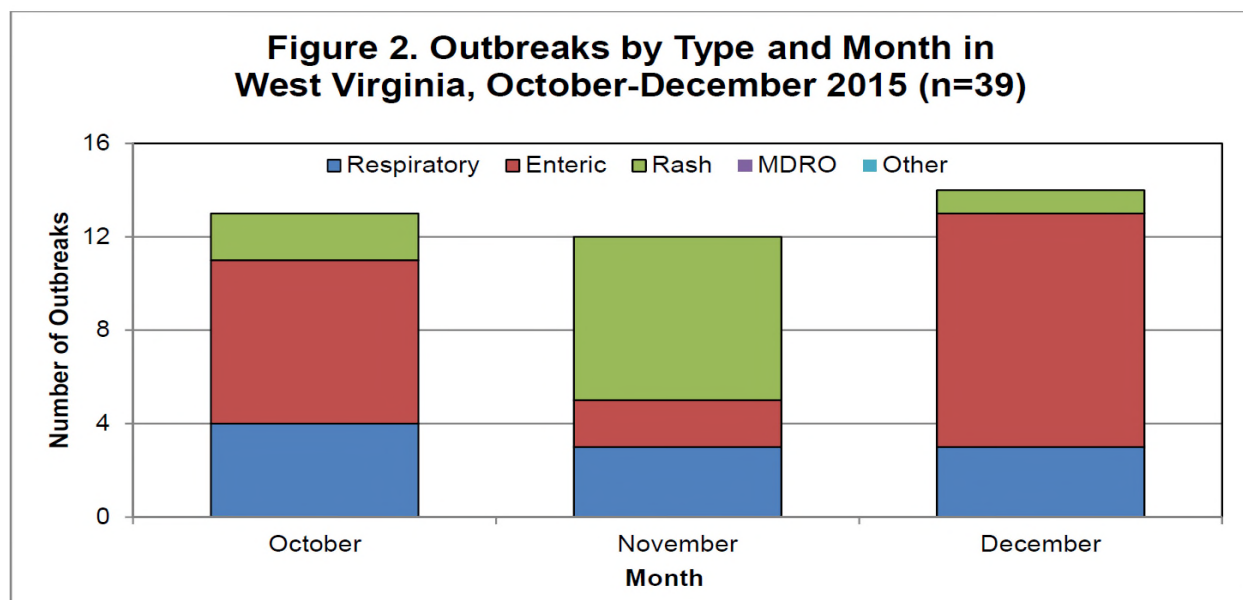
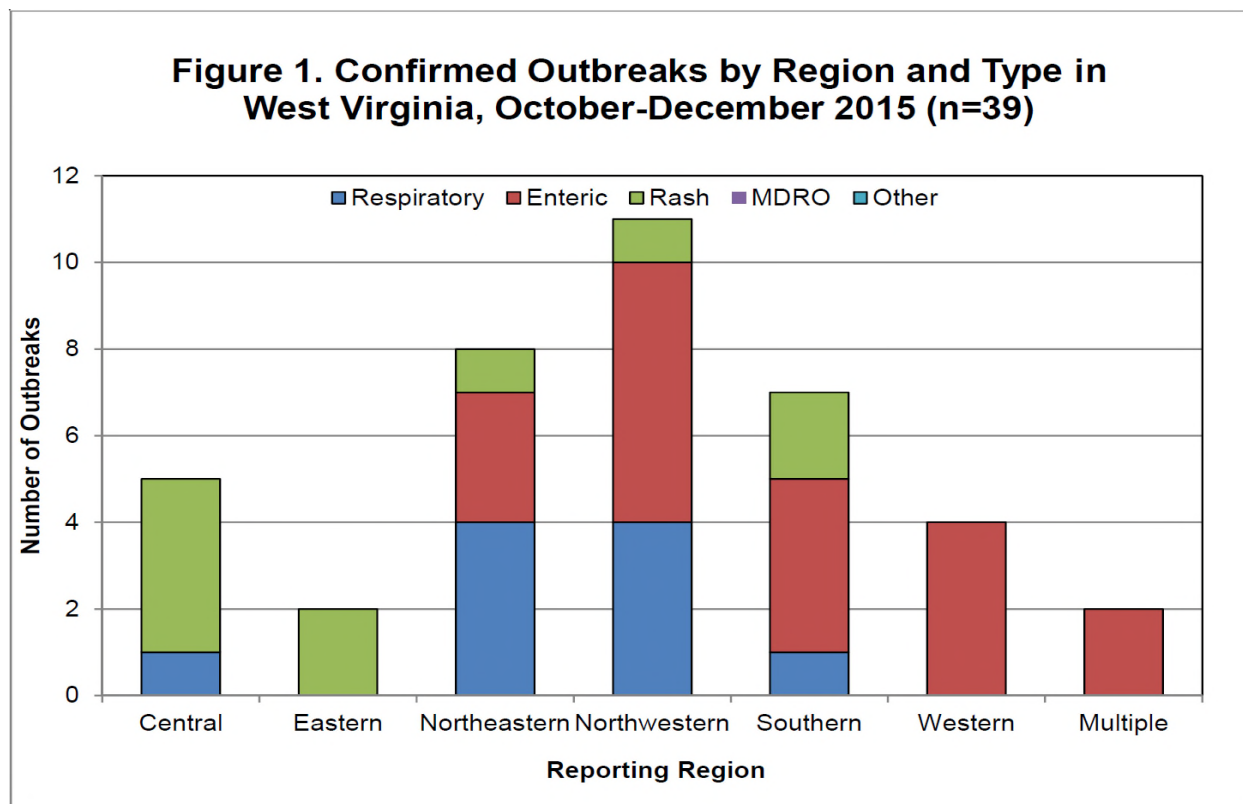
Type of Outbreak or Cluster	Number of Outbreaks	Outbreak Setting	Laboratory Testing
Acute Gastroenteritis	13	9 LTCFs	7 Not Done 2 Negative
		2 Schools	Not Done
		2 Communities	1 Not Done 1 Negative
Norovirus Gastroenteritis	2	2 LTCFs	Confirmed
Shiga toxin-producing <i>E. coli</i> (STEC) Gastroenteritis	1	1 Group Home	Confirmed
<i>Clostridium perfringens</i> Gastroenteritis	1	1 Correctional Facility	Confirmed
Salmonellosis	2	2 Multi-state	Confirmed

(See **Outbreaks**, page 9)



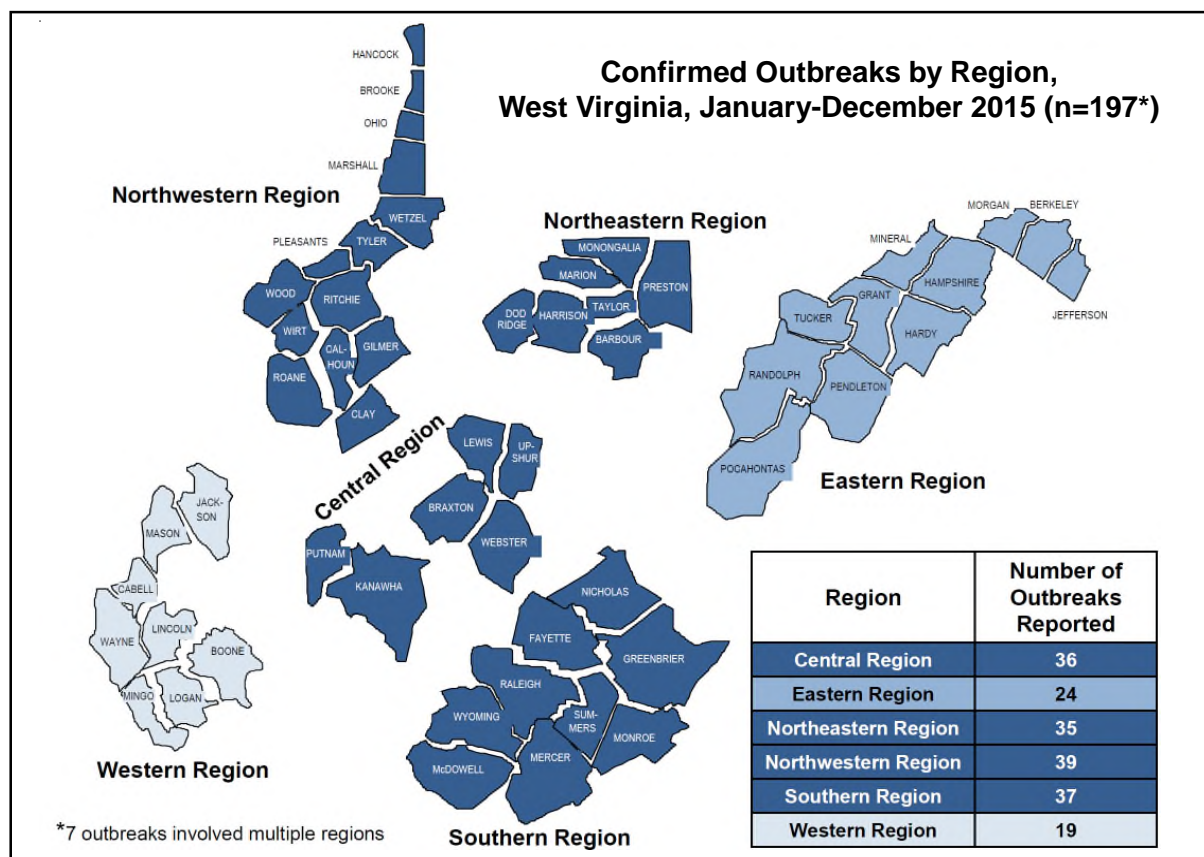
(*Outbreaks*, continued from page 8)

During this period, all surveillance regions reported outbreaks with a range from 2 to 11 outbreaks per region (Figure 1). Enteric outbreaks were the most common outbreaks reported during this period accounting for 49% of all confirmed outbreaks (Figure 2). Of the 19 confirmed outbreaks, only 7 (37%) had laboratory testing.



(See *Outbreaks*, page 10)

(*Outbreaks, continued from page 9*)



### Limitations

Data provided in this report are provisional since some investigations are ongoing.

### Conclusions

Fourth-quarter outbreaks were characterized by a rapid increase in the number of acute gastroenteritis outbreaks reported from long-term care facilities in December 2015. Local health departments and long-term care facilities should review norovirus outbreak management guidelines available at [www.dhhr.wv.gov/oeps/disease/ob/documents/toolkits/norovirus/norovirus-outbreak-hcf.pdf](http://www.dhhr.wv.gov/oeps/disease/ob/documents/toolkits/norovirus/norovirus-outbreak-hcf.pdf). Testing for norovirus in long-term care outbreaks is not necessary for management of the outbreak, but testing is useful for surveillance purposes and should always be performed when a point-source outbreak is suspected.

During fourth quarter, there was a high rate of laboratory confirmation on respiratory outbreaks. Laboratory confirmation of respiratory outbreaks is essential for proper management of the outbreak. Laboratory testing for foodborne and enteric bacterial outbreaks was also done consistently this quarter. Laboratory testing for foodborne outbreaks is critical.

To assist local health departments in outbreak investigations, the West Virginia Bureau for Public Health has published a variety of outbreak toolkits at [www.dhhr.wv.gov/oeps/disease/ob/Pages/OutbreakToolkits.aspx](http://www.dhhr.wv.gov/oeps/disease/ob/Pages/OutbreakToolkits.aspx). The toolkits consist of brief guidelines for defining, investigating and managing the outbreak and collecting laboratory specimens. Toolkits are available for most of the common outbreaks that occur in West Virginia.

For information on outbreak guidelines or any disease or condition, please visit the Division of Infectious Diseases Epidemiology's website at [www.dide.wv.gov](http://www.dide.wv.gov), call (304) 558-5358, or toll free in West Virginia at (800) 423-1271 at any time. ☒

*(Hepatitis, continued from page 6)*

One of the successes of this HBV vaccination program was the outreach efforts by most of the participating sites to correctional facilities and drug treatment centers. A major success of the program was vaccinating more high-risk populations in communities with high incidence rates for acute HBV. In the near future, West Virginia will show the positive outcomes of these efforts.

Some of the challenges for the participating sites were similar to those confronted by all of the awardees from this grant. There were problems getting patients to

return to the clinic to receive their second and third doses; some of the participating sites vaccinating for HBV had difficulty finding the time and staff to go to many places on a consistent basis; and completing the series on transient populations was difficult.

Within the next three years, we hope to see a significant impact in decreasing West Virginia's incidence of new HBV infections through this program's efforts in targeting high-risk population vaccinations through STD clinics and targeted outreach in substance abuse centers, correctional facilities and HIV treatment providers. ☒

*The **West Virginia EPI-LOG** is published quarterly by the West Virginia Department of Health and Human Resources, Bureau for Public Health, Office of Epidemiology & Prevention Services. Graphic layout by Chuck Anziulewicz. Please call the Office of Epidemiology & Prevention Services at (304) 558-5358 if you need additional information regarding any article or information in this issue. If you have ideas or contributions you would like to make in a future issue, ask for editor Loretta Haddy.*